Washington State PACT Program Standards

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I. Introduction

The Program for Assertive Community Treatment (PACT) is a client-centered recovery-oriented mental health service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs.

The important characteristics of PACT programs are:

- PACT serves clients with severe and persistent mental illness that are complex, have devastating effects on functioning, and, because of the limitations of traditional mental health services, may have gone without appropriate services. Consequently, the client group is often over represented among the homeless and in jails and prisons, and has been unfairly thought to resist or avoid involvement in treatment.
- PACT services are delivered by a group of multidisciplinary mental health staff who work as a team and provide the majority of the treatment, rehabilitation, and support services clients need to achieve their goals. The team is directed by a team leader and a psychiatric prescriber and includes a sufficient number of staff from the core mental health disciplines, at least one peer specialist, and a program or administrative support staff who work in shifts to cover 24 hours per day, seven days a week and to provide intensive services (multiple contacts may be as frequent as two to three times per day, seven days per week, which are based on client need and a mutually agreed upon plan between the client and PACT staff). Many, if not all, staff share responsibility for addressing the needs of all clients requiring frequent contact.
- PACT services are individually tailored with each client and address the preferences and identified goals of each client. The approach with each client emphasizes relationship building and active involvement in assisting individuals with severe and persistent mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals, and to maintain optimism.
- The PACT team is mobile and delivers services in community locations to enable each client to find and live in their own residence and find and maintain work in community jobs rather than expecting the client to come to the program. Seventy-five percent or more of the services are provided outside of the program offices in locations that are comfortable and convenient for clients.
- PACT services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of caregiver. Severe and persistent mental illnesses are episodic disorders and many clients benefit from the availability of a longer-term treatment approach and continuity of care. This allows clients opportunity to recompensate, consolidate gains, sometimes slip back, and then take the next steps forward until they achieve recovery.

II. Definitions

Program of Assertive Community Treatment (PACT) is a self-contained mental health program made up of a multidisciplinary mental health staff, including a peer specialist, who work as a team to provide the majority of treatment, rehabilitation, and support services clients need to achieve their goals. PACT services are individually tailored with each client through relationship building, individualized assessment and planning, and active involvement with clients to enable each to find and live in their own residence, to find and maintain work in community jobs, to better manage symptoms, to achieve individual goals, and to maintain optimism and recover. The PACT team is mobile and delivers services in community locations rather than expecting the

client to come to the program. Seventy-five percent or more of the services are provided outside of program offices in locations that are comfortable and convenient for clients. The clients served have severe and persistent mental illness that are complex, have devastating effects on functioning, and, because of the limitations of traditional mental health services, may have gone without appropriate services. There should be no more than 8-10 clients to one staff member.

PACT Service Coordination (Case Management) is a process of organization and coordination within the multidisciplinary team to carry out the range of treatment, rehabilitation, and support services each client expects to receive per his or her written individualized treatment plan and that are respectful of the client's wishes. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

PACT Service Coordinator (Case Manager) is the team member who has primary responsibility for establishing and maintaining a therapeutic relationship with a client on a continuing basis, whether the client is in the hospital, in the community, or involved with other agencies. In addition, the service coordinator leads and coordinates the activities of the individual treatment team (ITT). He or she is the responsible team member to be knowledgeable about the client's life, circumstances, and goals and desires. The service coordinator develops and collaborates with the client to write the treatment plan, offers options and choices in the treatment plan, ensures that immediate changes are made as the client's needs change, and advocates for the client's wishes, rights, and preferences. The service coordinator also works with other community resources, including consumer-run services, to coordinate activities and integrate other agency or service activities into the overall service plan with the client. The service coordinator provides individual supportive therapy and is the first ITT member available to the client in crisis and provides primary support and education to the family and/or support system and other significant people. The service coordinator shares these tasks with other members of the individual treatment team who are responsible to perform them when the service coordinator is not working.

Client is a person who has agreed to receive services and is receiving client-centered treatment, rehabilitation, and support services from the PACT team.

Client-Centered Individualized Treatment Plan is the culmination of a continuing process involving each client, his or her family, and the PACT team, which individualizes service activity and intensity to meet client-specific treatment, rehabilitation, and support needs. The written treatment plan documents the client's self-determined goals and the services necessary to help the client achieve them. The plan also delineates the roles and responsibilities of the team members who will carry out the services.

Clinical Supervision is a systematic process to review each client's clinical status and to ensure that the individualized services and interventions that the team members provide (including the peer specialist) are planned with, purposeful for, effective, and satisfactory to the client. The team leader and the psychiatric prescriber have the responsibility to provide clinical supervision which occurs during daily organizational staff meetings, treatment planning meetings, and in individual meetings with team members. Clinical supervision also includes review of written documentation (e.g., assessments, treatment plans, progress notes, correspondence).

Comprehensive Assessment is the organized process of gathering and analyzing current and past information with each client and the family and/or support system and other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment; and 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery. The results of the information gathering and analysis are used to establish immediate and longer-term service needs with each client and to set goals and develop the first individualized treatment plan with each client.

Daily Log is a notebook or cardex which the PACT team maintains on a daily basis to provide: 1) a roster of clients served in the program; and 2) for each client, a brief documentation of any treatment or service contacts which have occurred during the day and a concise behavioral description of the client's clinical status and any additional needs.

Daily Organizational Staff Meeting is a daily staff meeting held at regularly scheduled times under the direction of the team leader (or designee) to: 1) briefly review the service contacts which occurred the previous day and the status of all program clients; 2) review the service contacts which are scheduled to be completed during the current day and revise as needed; 3) assign staff to carry out the day's service activities; and 4) revise treatment plans and plan for emergency and crisis situations as needed. The daily log and the daily staff assignment schedule are used during the meeting to facilitate completion of these tasks.

Daily Staff Assignment Schedule is a written, daily timetable summarizing all client treatment and service contacts to be divided and shared by staff working on that day. The daily staff assignment schedule will be developed from a central file of all weekly client schedules.

Individual Treatment Team (ITT) is a group or combination of three to five PACT staff members who together have a range of clinical and rehabilitation skills and expertise. The ITT members are assigned to work with a client by the team leader and the psychiatric prescriber by the time of the first treatment planning meeting or thirty days after admission. The core members are the service coordinator (case manager), the psychiatric prescriber, and one clinical or rehabilitation staff person who backs up and shares case coordination tasks and substitutes for the service coordinator when he or she is not working. The individual treatment team has continuous responsibility to be knowledgeable about the client's life, circumstances, goals and desires; to collaborate with the client to develop and write the treatment plan; to offer options and choices in the treatment plan; to ensure that immediate changes are made as a client's needs change; and to advocate for the client's wishes, rights, and preferences. The ITT is responsible to provide much of the client's treatment, rehabilitation, and support services. Individual treatment team members are assigned to take separate service roles with the client as specified by the client and the ITT in the treatment plan.

Individual Supportive Therapy Counseling and Psychotherapy are verbal therapies that help people make changes in their feelings, thoughts, and behavior in order to move toward recovery, clarify goals, and address self stigma. Supportive therapy and psychotherapy also help clients understand and identify symptoms in order to find strategies to lessen distress and symptomatology, improve role functioning, and evaluate treatment and rehabilitative services. Current psychotherapy approaches include cognitive behavioral therapy, personal therapy, and psychoeducational therapy.

Initial Assessment and Client-Centered Individualized Treatment Plan is the initial evaluation of: 1) the client's mental and functional status; 2) the effectiveness of past treatment; and 3) the current treatment, and rehabilitation and support service needs. The results of the information gathering and analysis are used to establish the initial treatment plan to achieve individual goals and support recovery. Completed the day of admission, the client's initial assessment and treatment plan guides team services until the comprehensive assessment and treatment plan is completed.

Medication Distribution is the physical act of giving medication to clients in a PACT program by the prescribed route which is consistent with state law and the licenses of the professionals privileged to prescribe and/or administer medication (e.g., psychiatric prescribers, registered nurses, and pharmacists).

Medication Error is any error in prescribing or administering a specific medication, including errors in writing or transcribing the prescription, in obtaining and administering the correct medication, in the correct dosage, in the correct form, and at the correct time.

Medication Management is a collaborative effort between the client and the psychiatric prescriber with the participation of the Individual Treatment Team (ITT) to carefully evaluate the client's previous experience with psychotropic medications and side-effects; to identify and discuss the benefits and risks of psychotropic and other medication; to choose a medication treatment; and to establish a method to prescribe and evaluate medication according to evidence-based practice standards. The goal of medication management is client self-medication management.

Peer Counseling is counseling and support provided by team members who have experience as recipients of mental health services for severe and persistent mental illness. Drawing on common experiences as well as using and sharing his/her own practical experiences and knowledge gained as a recipient, peer counseling is supportive counseling that validates clients' experiences and provides guidance and encouragement to clients to take responsibility and actively participate in their own recovery.

Psychiatric and Social Functioning History Time Line is a format or system which helps PACT staff to organize chronologically information about significant events in a client's life, experience with mental illness, and treatment history. This format allows staff to more systematically analyze and evaluate the information with the client, to formulate hypotheses for treatment with the client, and to determine appropriate treatment and rehabilitation approaches and interventions with the client.

Psychotropic Medication is any drug used to treat, manage, or control psychiatric symptoms or disordered behavior, including but not limited to antipsychotic, antidepressant, mood-stabilizing or antianxiety agents.

Shift Manager is the individual (assigned by the team leader) in charge of developing and implementing the daily staff assignment schedule; making all daily assignments; ensuring that all daily assignments are completed or rescheduled; and managing all emergencies or crises that arise during the course of the day, in consultation with the team leader and the psychiatric prescriber.

Stakeholder Advisory Groups support and guide individual PACT team implementation and operation. Each PACT team shall have a Stakeholder Advisory Group whose membership consists of 51 percent mental health consumers and family members. It shall also include community stakeholders that interact with persons with severe and persistent mental illness (e.g., homeless services, food-shelf agencies, faith-based entities, criminal justice system, the housing authority, landlords, employers, and community colleges). In addition, group membership shall represent the local cultural populations. The group's primary function is to promote quality PACT programs; monitor fidelity to the PACT Standards; guide and assist the administering agency's oversight of the PACT program; problem-solve and advocate to reduce barriers to PACT implementation; and monitor/review/mediate client and family grievances or complaints. The Stakeholder Advisory Group promotes and ensures clients' empowerment and recovery values in PACT programs.

Treatment Plan Review is a thorough, written summary describing the client's and the individual treatment team's evaluation of the client's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last treatment plan.

Treatment Planning Meeting is a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatric prescriber. The purpose of these meetings is for the staff, as a team, to thoroughly prepare for their work with each client. The team meets together to present and integrate the information collected through assessment in order to learn as much as possible about the client's life, their experience with mental illness, and the type and effectiveness of the past treatment they have received. The presentations and discussions at these meetings make it

possible for all staff to be familiar with each client and their goals and aspirations; to participate in the ongoing assessment and reformulation of issues/problems; to problem-solve treatment strategies and rehabilitation options; and to fully understand the treatment plan rationale in order to carry out the plan for each client.

Weekly Client Contact Schedule is a written schedule of the specific interventions or service contacts (i.e., by whom, when, for what duration, and where) which fulfill the goals and objectives in a given client's treatment plan. The individual treatment team (ITT) shall maintain an up-to-date weekly client contact schedule for each client per the client-centered individualized treatment plan.

III. Admission and Discharge Criteria

A. Admission Criteria

Individuals must meet the following admission criteria:

1. Severe and persistent mental illness listed in the diagnostic nomenclature (currently the Diagnostic and Statistical Manual, Fourth Edition, or DSM IV, of the American Psychiatric Association) that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Clients with other psychiatric illnesses are eligible dependent on the level of the long-term disability. (Individuals with a primary diagnosis of a substance use disorder or mental retardation are not the intended client group.)

2. Significant functional impairments as demonstrated by <u>at least one</u> of the following conditions:

    a. Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
    b. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).
    c. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).

3. Continuous high-service needs as demonstrated by <u>at least one</u> of the following:

    a. High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services.
    b. Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
    c. Coexisting substance use disorder of significant duration (e.g., greater than six months).
    d. High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).
    e. Significant difficulty meeting basic survival needs or residing in substandard housing, homelessness, or at imminent risk of becoming homeless.

f. Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
g. Difficulty effectively utilizing traditional office-based outpatient services.

4. Documentation of admission shall include:

a. The reasons for admission as stated by both the client and the PACT team.
b. The signature of the psychiatric prescriber.

B. Discharge Criteria

1. Discharges from the PACT team occur when clients and program staff mutually agree to the termination of services. This shall occur when clients:

a. Have successfully reached individually established goals for discharge and when the client and program staff mutually agree to the termination of services.
b. Move outside the geographic area of PACT's responsibility. In such cases, the PACT team shall arrange for transfer of mental health service responsibility to a PACT program or another provider wherever the client is moving. The PACT team shall maintain contact with the client until this service transfer is arranged.
c. Demonstrate an ability to function in all major role areas (i.e., work, social, self-care) without requiring ongoing assistance from the program for at least two years without significant relapse when services are withdrawn.
d. Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable treatment plan with the client.

2. Documentation of discharge shall include:

a. The reasons for discharge as stated by both the client and the PACT team.
b. The client's biopsychosocial status at discharge.
c. A written final evaluation summary of the client's progress toward the goals set forth in the treatment plan.
c. A plan developed in conjunction with the client for follow-up treatment after discharge.
d. The signature of the client, the client's service coordinator, the team leader, and the psychiatric prescriber.

Policy and Procedure Requirements: The PACT team shall maintain written admission and discharge policies and procedures.

IV. Service Intensity and Capacity

A. Staff-to-Client Ratio

Each PACT team shall have the organizational capacity to provide a minimum staff-to-client ratio of at least one full-time equivalent (FTE) staff person for every 10 clients (not including the psychiatric prescriber and the program assistant) for an urban team. Rural teams shall have the organizational capacity to provide a minimum staff-to-client ratio of at least one full-time equivalent (FTE) staff person for every 8 clients (not including the psychiatric prescriber and the program assistant).

B. Staff Coverage

Each PACT team shall have sufficient numbers of staff to provide treatment, rehabilitation, and support services 24 hours a day, seven days per week.

C. Frequency of Client Contact

1. The PACT team shall have the capacity to provide multiple contacts per week with clients experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment, or having significant ongoing problems in daily living. These multiple contacts may be as frequent as two to three times per day, seven days per week and depend on client need and a mutually agreed upon plan between clients and program staff. Many, if not all, staff shall share responsibility for addressing the needs of all clients requiring frequent contact.

2. The PACT team shall have the capacity to rapidly increase service intensity to a client when his or her status requires it or a client requests it.

3. The PACT team shall provide a mean (i.e., average) of three contacts per week for all clients. Data regarding the frequency of client contacts shall be collected and reviewed as part of the program's Continuous Quality Improvement (CQI) plan.

D. Gradual Admission of Team Clients

Each new PACT team shall stagger client admissions (e.g., 4-6 clients per month) to gradually build up capacity to serve no more than 100-120 clients (with 10-12 staff) on any given urban team and no more than 42-50 clients (with 6-8 staff) on any given rural team.

V. Staff Requirements

A. Qualifications

The PACT team shall have among its staff persons with sufficient individual competence and professional qualifications and experience to provide the services described in Section VIII, including service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; medication prescription, administration, monitoring and documentation; substance abuse treatment; work-related services; activities of daily living services; social, interpersonal relationship and leisure-time activity services; support services or direct assistance to ensure that clients obtain the basic necessities of daily life; and education, support, and consultation to clients' families and other major supports. The staff should have sufficient representation of the local cultural population that the team serves.

B. Team Size

1. The **urban program** shall employ a minimum of 10 to 12 FTE multidisciplinary clinical staff persons including the team leader, 1 FTE peer specialist, one to 1.5 FTE program assistants, and 16 hours of psychiatric prescriber time for very 50 clients on the team.

2. The **rural program** shall employ a minimum of 6 to 8 FTE multidisciplinary clinical staff persons, including one team leader, one FTE peer specialist, one FTE program assistant, and 16 hours of psychiatric prescriber time for every 50 clients on the team.

C. Mental Health Professional

Of the 10 to 12 FTE multidisciplinary clinical staff positions on an urban team, there are a minimum of 8 FTE mental health professionals (including one FTE team leader). On a rural team of 6 to 8 FTE multidisciplinary clinical staff, there are a minimum of 4.5 FTE mental health professionals. Mental health professionals have: 1) professional degrees in one of the core mental health disciplines; 2) clinical training including internships and other supervised practical experiences in a clinical or rehabilitation setting; and 3) clinical work experience with persons with severe and persistent mental illness. They are licensed or certified per the regulations of the state where the team is located and operate under the code of ethics of their professions. Mental health professionals include persons with master's or doctoral degrees in nursing, social work, rehabilitation counseling, or psychology; diploma, associate, and bachelor's nurses (i.e., registered nurse); and registered occupational therapists.

1. Required among the mental health professionals are: 1) on an urban team, 5 FTE or at least 4 FTE registered nurses and 2) on a rural team, 2 FTE or at least 1.5 FTE registered nurses (for either team, a team leader with a nursing degree cannot replace one of these FTE nurses).

2. Also required among the mental health professionals are: 1) on an urban team, a minimum of 4 FTE master's level or above mental health professionals (in addition to the team leader) with at least one designated for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling; and 2) on a rural team, a minimum of 2 FTE master's level or above mental health professionals (in addition to the team leader) with designated responsibility for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling.

One or more mental health professionals with training and experience in substance abuse assessment and treatment shall be designated the role of substance abuse specialist.

The chart below shows the required staff on urban and rural teams.

Position	Urban	Rural
Team leader	1 FTE	1 FTE
Psychiatric prescriber	16 Hours for 50 Clients	16 Hours for 50 Clients
Registered Nurse	5 FTE or at Least 3 FTE	2 FTE or at Least 1.5 FTE
Peer Specialist	1 FTE	1 FTE
Master's level	4 FTE	2 FTE
Other level	1-3 FTE	1.5 – 2.5 FTE
Program/Administrative Assistant	1-1.5 FTE	1 FTE

D. Required Staff

1. ***Team Leader:*** A full-time team leader/supervisor who is the clinical and administrative supervisor of the team and who also functions as a practicing clinician on the PACT team. The team leader has at least a master's degree in nursing, social work, psychiatric rehabilitation or psychology, or is a psychiatric prescriber.

2. ***Psychiatric Prescriber:*** A psychiatric prescriber may include a psychiatrist or a psychiatric nurse practitioner/clinical specialist in psychiatric-mental health nursing (per WAC 246-840-300). The psychiatric prescriber works on a full-time or part-time basis for a minimum of 16 hours per week for every 50 clients. The psychiatric prescriber provides clinical services to all PACT clients; works with the team leader to monitor each client's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services.

3. ***Registered Nurses:*** On an urban team, five FTE registered nurses or at least 3 FTE registered nurses, and on a rural team, 2 FTE registered nurses or at least 1.5 FTE registered. A team leader with a nursing degree cannot replace one of the FTE nurses.

4. ***Master's Level Mental Health Professionals:*** On an urban team, a minimum of 4 FTE master's level or above mental health professionals (in addition to the team leader) with at least one designated for the role of **vocational specialist**, preferably with a master's degree in rehabilitation counseling. On a rural team, a minimum of 2 FTE master's level or above mental health professionals (in addition to the team leader) with designated responsibility for the role of **vocational specialist**, preferably with a master's degree in rehabilitation counseling.

5. ***Substance Abuse Specialist:*** One or more mental health professionals with training and experience in substance abuse assessment and treatment shall be designated the role of substance abuse specialist.

6. ***Peer Specialist:*** A minimum of one FTE peer specialist on either an urban team or a rural team. A person who is or has been a recipient of mental health services for severe and persistent mental illness holds this position. Because of their life experience with mental illness and mental health services, the peer specialist provides expertise that professional training cannot replicate. Peer specialists are fully integrated team members who provide highly individualized services in the community and promote client self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each client's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.

7. ***Remaining Clinical Staff:*** The remaining clinical staff may be bachelor's level and paraprofessional mental health workers who carry out rehabilitation and support functions. A bachelor's level mental health worker has a bachelor's degree in social work or a behavioral science, and work experience with adults with severe and persistent mental illness. A paraprofessional mental health worker may have a bachelor's degree in a field other than behavioral sciences or have a high school degree and work experience with adults with severe and persistent mental illness or with individuals with similar human-services needs. Those paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience.

8. ***Program/Administrative Assistant:*** The program/administrative assistant (1-1.5 FTE in an urban setting or 1 FTE in a rural setting) who is responsible for organizing, coordinating, and monitoring all nonclinical operations of PACT, including managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for client and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and clients.

Policy and Procedure Requirements: The PACT team shall: 1) maintain written personnel policies and procedures for hiring; 2) establish core staff competencies, orientation, and training; and 3) maintain personnel files for each team member containing the job application, copies of credentials or licenses, position description, annual performance appraisals, and individual orientation and training plan.

VI. Program Organization and Communication

A. Hours of Operation and Staff Coverage

1. Urban Teams

a. The PACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week. This means:
    i. Regularly operating and scheduling staff to work two eight-hour shifts with a minimum of 2 staff on the second shift providing services at least 12 hours per day weekdays.
    ii. Regularly operating and scheduling staff to work one eight- hour shift with a minimum of 2 staff each weekend day and every holiday.
    iii. Regularly scheduling mental health professionals on-call duty to provide crisis services and deliver services the hours when staff are not working. PACT team staff who are experienced in the program and skilled in crisis-intervention procedures shall be on call and available to respond to clients by telephone or by going out to see clients who need face-to-face contact.
    iv. Regularly arranging for and providing psychiatric backup all hours the psychiatric prescriber is not regularly scheduled to work. If availability of the PACT psychiatric prescriber during all hours is not feasible, alternative psychiatric backup should be arranged (e.g., mental health center psychiatric prescriber, emergency room psychiatric prescriber).

2. Rural Teams

a. The PACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week. When a rural team does not have sufficient staff numbers to operate two eight-hour shifts weekdays and one eight-hour shift weekend days and holidays, staff are regularly scheduled to provide the necessary services on a client-by-client basis (per the client-centered comprehensive assessment and individualized treatment plan) in the evenings and on weekends. This means:
    i. Regularly scheduling staff to cover client contacts in the evenings and on weekends.
    ii. Regularly scheduling mental health professionals on-call duty to provide crisis services and deliver services the hours when staff are not working. PACT team staff who are experienced in the program and skilled in crisis-intervention procedures shall be on call and available to respond to clients by telephone or in person.
    iii. When a rural team does not have sufficient staff numbers to operate an after-hours on-call system, the staff should provide crisis services during regular work hours. During all other hours, the team may arrange coverage through a reliable crisis-intervention service. The rural team communicates routinely with the crisis-intervention service (i.e., at the beginning of the workday to obtain information from the previous evening and at the end of the workday to alert the crisis-intervention service to clients who may need assistance and to provide effective ways for helping them). The crisis-intervention

service should be expected to go out and see clients who need face-to-face contact.

iv. Regularly arranging for and providing psychiatric backup all hours the psychiatric prescriber is not regularly scheduled to work. If availability of the PACT psychiatric prescriber during all hours is not feasible, alternative psychiatric prescriber backup should be arranged (e.g., mental health center psychiatric prescriber, emergency room psychiatric prescriber).

B. Place of Treatment

Each new urban team shall set a goal of providing 75 percent of service contacts in the community in nonoffice-based or nonfacility-based settings, while each new rural team shall set a goal of providing 85 percent of service contacts in the community in nonoffice-based or nonfacility-based settings. Data regarding the percentage of client contacts in the community will be collected and reviewed to verify that goals are being met as part of the program's Continuous Quality Improvement (CQI) plan.

C. Staff Communication and Planning

1. The PACT team shall conduct **daily organizational staff meetings** at regularly scheduled times per a schedule established by the team leader. These meetings will be conducted in accordance with the following procedures:

   a. The PACT team shall maintain a written **daily log**, using either a notebook or a cardex. The daily log provides:

      i. A roster of the clients served in the program, and
      ii. For each client, a brief documentation of any treatment or service contacts that have occurred during the last 24 hours and a concise, behavioral description of the client's status that day.

   b. The **daily organizational staff meeting** shall commence with a review of the daily log to update staff on the treatment contacts which occurred the day before and to provide a systematic means for the team to assess the day-to-day progress and status of all clients.

   c. The PACT team, under the direction of the team leader, shall maintain a **weekly client schedule** for each client. The weekly client schedule is a written schedule of all treatment and service contacts that staff must carry out to fulfill the goals and objectives in the client's treatment plan. The team will maintain a central file of all weekly client schedules.

   d. The PACT team, under the direction of the team leader, shall develop a **daily staff assignment schedule** from the central file of all weekly client schedules. The daily staff assignment schedule is a written timetable for all the client treatment and service contacts and all indirect client work (e.g., medical record review, meeting with collaterals, job development, treatment planning, and documentation) to be done on a given day, to be divided and shared by the staff working on that day.

   e. The daily organizational staff meeting will include a **review by the shift manager of all the work to be done that day** as recorded on the daily staff assignment schedule. During the meeting, the shift manager will assign and supervise staff to carry out the treatment and service activities scheduled to occur that day, and the shift manager will be responsible for assuring that all tasks are completed.

f. During the **daily organizational staff meeting**, the PACT team shall also revise treatment plans as needed, plan for emergency and crisis situations, and add service contacts to the daily staff assignment schedule per the revised treatment plans.

2. The PACT team shall conduct **treatment planning meetings** under the supervision of the team leader and the psychiatric prescriber. These treatment planning meetings shall:

   a. Convene at regularly scheduled times per a written schedule maintained by the team leader.

   b. Occur and be scheduled when the majority of the team members can attend, including the psychiatric prescriber, team leader, and all members of the ITT.

   c. Require individual staff members to present and systematically review and integrate client information into a holistic analysis and prioritize issues.

   d. Occur with sufficient frequency and duration to make it possible for all staff to be familiar with each client and their goals and aspirations; to participate in the ongoing assessment and reformulation of issues/problems; to problem-solve treatment strategies and rehabilitation options; to participate with the client and the ITT in the development and the revision of the treatment plan; and to fully understand the treatment plan rationale in order to carry out the plan for each client every six months.

D. Staff Supervision

Each PACT team shall develop a written policy for clinical supervision of all staff providing treatment, rehabilitation, and support services. The team leader and psychiatric prescriber shall assume responsibility for supervising and directing all staff activities. This supervision and direction shall consist of:

1. Individual, side-by-side sessions in which the supervisor accompanies an individual staff member to meet with clients in regularly scheduled or crisis meetings to assess their performance, give feedback, and model alternative treatment approaches;

2. Participation with team members in daily organizational staff meetings and regularly scheduled treatment planning meetings to review and assess staff performance and provide staff direction regarding individual cases;

3. Regular meetings with individual staff to review their work with clients, assess clinical performance, and give feedback;

4. Regular reviews, critiques, and feedback of staff documentation (i.e., progress notes, assessments, treatment plans, treatment plan reviews); and

5. Written documentation of all clinical supervision provided to PACT team staff.

Policy and Procedure Requirements: The PACT team shall maintain written program organization policies and procedures, including required hours of operation and coverage, staff communication and planning, emphasis on team approach, and staff supervision, as outlined in this section.

VII. Client-Centered Assessment and Individualized Treatment Planning

A. Initial Assessment

An initial assessment and treatment plan shall be done the day of the client's admission to PACT by the team leader or the psychiatric prescriber, with participation by designated team members.

B. Comprehensive Assessment

Each part of the assessment area shall be completed by an PACT team member with skill and knowledge in the area being assessed. A team member with training and interest in the area does each part and becomes the specialist in that particular area with the client. The assessment is based upon all available information, including that from client interview/self-report, family members and other significant parties, and written summaries from other agencies, including police, courts, and outpatient/inpatient facilities, where applicable. A comprehensive assessment shall be initiated and completed within one month after a client's admission according to the following requirements:

1. In collaboration with the client, the ITT will complete a psychiatric and social functioning history time line.

2. In collaboration with the client, the comprehensive assessment shall include an evaluation in the following areas:

    a. ***Psychiatric History, Mental Status, and Diagnosis:*** The psychiatric prescriber is responsible for completing the psychiatric history, mental status, and diagnosis assessment. (Using information derived from the evaluation, a psychiatric prescriber or a clinical or counseling psychologist shall make an accurate diagnosis listed in the American Psychiatric Association's DSM IV.) The psychiatric prescriber presents the assessment findings at the first treatment planning meeting.

    b. ***Physical Health:*** A registered nurse is responsible for completing the physical health assessment. The registered nurse presents the assessment findings at the first treatment planning meeting.

    c. ***Use of Drugs and Alcohol:*** A team member with experience and training in dual diagnosis substance abuse assessment and treatment is responsible for completing the use of drugs and alcohol assessment. The substance abuse specialist presents the assessment findings at the first treatment planning meeting.

    d. ***Education and Employment:*** A team member with experience and training in vocational assessment and services is responsible for completing the education and employment assessment. The vocational specialist presents the assessment findings at the first treatment planning.

    e. ***Social Development and Functioning:*** A team member who is interested and skillful in attainment and restoration of social/interpersonal skills and relationships and who is knowledgeable about human development is responsible for completing the social development and functioning assessment. The team member who does the assessment presents the assessment findings at the first treatment planning meeting.

f. ***Activities of Daily Living (ADL):*** Occupational therapists and nurses are responsible to complete the ADL assessment because team members in these professions have training to conduct ADL assessments. Other staff members with training to do the assessment and who have interest in and compassion for clients in this area may complete the ADL assessment. The team member who does the assessment presents assessment findings at the first treatment planning meeting.

g. ***Family Structure and Relationships:*** Members of the client's individual treatment team (ITT) are responsible to carry out the family structure and relationships assessment. The staff members working with the family present the assessment findings at the first treatment planning meeting.

3. While the assessment process shall involve the input of most, if not all, team members, the client's psychiatric prescriber, service coordinator (case manager), and ITT members will assume responsibility for preparing the written narrative of the results and formulation of the psychiatric and social functioning history time line and the comprehensive assessment, ensuring that a psychiatric and social functioning history time line and comprehensive assessment are completed within one month of the client's admission to the program.

4. The service coordinator and ITT members will be assigned by the team leader in collaboration with the psychiatric prescriber by the time of the first treatment planning meeting or thirty days after admission.

C. Individualized Treatment Planning

Treatment plans will be developed through the following treatment planning process:

1. The treatment plan shall be developed in collaboration with the client and the family or guardian, if any, when feasible and appropriate. The client's participation in the development of the treatment plan shall be documented. The PACT team shall evaluate together with each client their needs, strengths, and preferences and develop together with each client an individualized treatment plan. The treatment plan shall identify individual issues/problems; set specific long- and short-term goals for each issue/problem which are measurable; establish the specific approaches and interventions necessary for the client to meet his or her goals, improve his or her capacity to function as independently as possible in the community, achieve the maximum level of recovery possible (i.e., meaningful, satisfying, and productive life).

2. As described in Section VI, PACT team staff shall meet at regularly scheduled times for treatment planning meetings. At each treatment planning meeting the following staff should attend: the team leader, the psychiatric prescriber, the service coordinator (case manager), individual treatment team members, the peer specialist and all other PACT team members involved in regular tasks with the client.

3. Individual treatment team members are responsible to ensure the client is actively involved in the development of treatment (recovery) and service goals. With the permission of the client, PACT team staff shall also involve pertinent agencies and members of the client's social network in the formulation of treatment plans.

4. Each client's treatment plan shall identify issues/problems, strengths/ weaknesses, and specific measurable goals. The treatment plan must clearly specify the approaches and interventions necessary for the client to achieve the individual goals (achieve recovery) and identify who will carry out the approaches and interventions.

5. The following key areas should be addressed in every client's treatment plan: psychiatric illness or symptom reduction; housing; ADL; daily structure and employment; and family and social relationships. The service coordinator (case manager) and the individual treatment team, together with the client, will be responsible for reviewing and rewriting the treatment goals and plan whenever there is a major decision point in the client's course of treatment (e.g., significant change in client's condition or goals) or at least every six months. Additionally, the service coordinator shall prepare a summary (i.e., treatment plan review) which thoroughly describes in writing the client's and the ITT's evaluation of his or her progress/goal attainment, the effectiveness of the interventions, and the satisfaction with services since the last treatment plan. The plan and review will be signed or acknowledged by the client, the service coordinator, individual treatment team members, the team leader, the psychiatric prescriber, and all PACT team members.

Policy and Procedure Requirement: The PACT team shall maintain written assessment and treatment planning policies and procedures incorporating the requirements outlined in this section.

VIII. Required Services

Operating as a continuous treatment service, the PACT team shall have the capability to provide comprehensive treatment, rehabilitation, and support services as a self-contained service unit.

Services shall minimally include the following:

A. Service Coordination

Each client will be assigned a service coordinator (case manager) who coordinates and monitors the activities of the client's individual treatment team and the greater PACT team. The primary responsibility of the service coordinator is to work with the client to write the treatment plan, to provide individual supportive counseling, to offer options and choices in the treatment plan, to ensure that immediate changes are made as the client's needs change, and to advocate for the client's wishes, rights, and preferences. The service coordinator is also the first staff person called on when the client is in crisis and is the primary support person and educator to the individual client's family. Members of the client's individual treatment team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is not working. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

B. Crisis Assessment and Intervention

Crisis assessment and intervention shall be provided 24 hours per day, seven days per week. These services will include telephone and face-to-face contact and will be provided in conjunction with the local mental health system's emergency services program as appropriate.

C. Symptom Assessment and Management

This shall include but is not limited to the following:

1. Ongoing comprehensive assessment of the client's mental illness symptoms, accurate diagnosis, and the client's response to treatment

2. Psychoeducation regarding mental illness and the effects and side effects of prescribed medications, when appropriate

3. Symptom-management efforts directed to help each client identify/target the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects

4. Individual supportive therapy

5. Psychotherapy
6. Generous psychological support to clients, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to recover

D. Medication Prescription, Administration, Monitoring and Documentation

1. The PACT team psychiatric prescriber shall:

    a. Establish an individual clinical relationship with each client
    b. Assess each client's mental illness symptoms and provide verbal and written information about mental illness
    c. Make an accurate diagnosis based on the comprehensive assessment which dictates an evidence-based medication pathway that the psychiatric prescriber will follow
    d. Provide education about medication, benefits and risks, and obtain informed consent
    e. Assess and document the client's mental illness symptoms and behavior in response to medication and shall monitor and document medication side effects
    f. Provide psychotherapy

2. All PACT team members shall assess and document the client's mental illness symptoms and behavior in response to medication and shall monitor for medication side effects.

3. The PACT team program shall establish medication policies and procedures which identify processes to:

    a. Record physician orders
    b. Order medication
    c. Arrange for all client medications to be organized by the team and integrated into clients' weekly schedules and daily staff assignment schedules
    d. Provide security for medications (e.g., long-term injectable, daily, and longer term supplies) and set aside a private designated area for set up of medications by the team's nursing staff
    e. Administer medications per state law to team clients

E. Dual Diagnosis Substance Abuse Services

Provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance abuse, and has client-determined goals. This shall include but is not limited to individual and group interventions in:

1. Engagement (e.g., empathy, reflective listening, avoid argumentation)

2. Assessment (e.g., stage of readiness to change, client-determined problem identification)

3. Motivational enhancement (e.g., developing discrepancies, psychoeducation)

4. Active treatment (e.g., cognitive skills training, community reinforcement)

5. Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans)

Prochaska, J.O., DiClemente, C. C. The transtheoretical approach: Crossing traditional boundaries of therapy. Homewood, IL: Dow Jones/Irwin. 1984.
Monti, P., Abrams, D., Caden, R., & Cooney, N. Treating Alcohol Dependence. New York: Gilford. 1989.
Meyers, R. & Smith, J. Clinical Guide to Alcohol Treatment. New York: Guilford. 1995.

F. Work-Related Services

Work-related services to help clients value, find, and maintain meaningful employment in community-based job sites and involve job development and coordination with employers but also includes but not necessarily limited to:

1. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs

2. Assessment of the effect of the client's mental illness on employment with identification of specific behaviors that interfere with the client's work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations

3. Development of an ongoing employment rehabilitation plan to help each client establish the skills necessary to find and maintain a job

4. Individual supportive therapy to assist clients to identify and cope with the symptoms of mental illness that may interfere with their work performance

5. On-the-job or work-related crisis intervention

6. Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation

G. Activities of Daily Living Services

Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist clients to gain or use the skills required to:

1. Find housing which is safe, good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, and decorating; and procuring necessities (such as telephones, furnishings, linens)

2. Perform household activities, including house cleaning, cooking, grocery shopping, and laundry

3. Carry out personal hygiene and grooming tasks, as needed

4. Develop or improve money-management skills

5. Use available transportation

6. Have and effectively use a personal physician and dentist

H. Social/Interpersonal Relationship and Leisure-Time Skill Training

Services to support social/interpersonal relationships and leisure-time skill training include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social-skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure clients' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:

1. Improve communication skills, develop assertiveness, and increase self-esteem, as necessary

2. Develop social skills, increase social experiences, and where appropriate, develop meaningful personal relationships

3. Plan appropriate and productive use of leisure time

4. Relate to landlords, neighbors, and others effectively

5. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities

I. Peer Support and Wellness Recovery Services

Services to validate clients' experiences and to guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, services to help clients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce clients' self-imposed stigma:

1. Illness Management and Recovery (IMR) services

2. Wellness Recovery and Action Plan (WRAP) services

3. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery

4. Other peer counseling and support

J. Support Services

Support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to:

1. Medical and dental services

2. Safe, clean, affordable housing

3. Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Vocational Rehabilitation, Home Energy Assistance)

4. Social service

5. Transportation

6. Legal advocacy and representation

K. Education, Support, and Consultation to Clients' Families and 0ther Major Supports

Services provided under this category to clients' families and other major supports with client agreement or consent, include:

1. Individualized psychoeducation about the client's illness and the role of the family in the therapeutic process

2. Individualized psychoeducation about the client's illness and the role of other significant people in the therapeutic process

3. Family intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people

4. Ongoing communication and collaboration, face-to-face and by telephone, between the PACT team and the family

5. Introduction and referral to family self-help programs and advocacy organizations that promote recovery

6. Assistance to clients with their children, including individual supportive counseling, parenting training, and service coordination but not limited to:

    a. Services to help clients throughout pregnancy and the birth of a child
    b. Services to fulfill parenting responsibilities and coordinating services for the child
    c. Services to restore relationships with children who are not in the client's custody

Policy and Procedure Requirement: The PACT team shall maintain written policies and procedures for all services outlined in this section.

IX. Client Medical Record

A. The PACT team shall maintain a treatment record for each client.

B. The treatment record is confidential, complete, accurate, and contains up-to-date information relevant to the client's care and treatment.

C. The record shall accurately document assessments, treatment plans, and the nature and extent of services provided, such as a person unfamiliar with the PACT team can easily identify the client's treatment needs and services received.

D. The team leader and the program assistant shall be responsible for the maintenance and security of the client treatment records.

E. The client records are located at PACT team headquarters and, for confidentiality and security, are to be kept in a locked file.

F. For purposes of confidentiality, disclosure of treatment records by the PACT team is subject to all the provisions of applicable state and federal laws.

G. Clients shall be informed by staff of their right to review their record and the process involved to request to do so.

H. Each client's clinical record shall be available for review and to be copied by the client and the guardian, if any.

Policy and Procedure Requirement: The PACT team shall maintain written medical records management policies and procedures.

X. Client Rights and Grievance Procedures

A. PACT teams shall be knowledgeable about and familiar with client rights including the rights to:

1. Confidentiality
2. Informed consent to medication and treatment
3. Treatment with respect and dignity
4. Prompt, adequate, and appropriate treatment
5. Treatment which is under the least restrictive conditions
6. Nondiscrimination
7. Control of own money
8. Grieve or complain

B. PACT teams shall be knowledgeable about and familiar with the mechanisms to implement and enforce client rights:

1. Grievance or complaint procedures under state law
2. Medicaid
3. Americans with Disabilities Act
4. Protection and Advocacy for Mentally Ill Individuals

C. PACT teams shall be prepared and provide clients appropriate information and referral to the Protection and Advocacy agency and other advocacy groups.

Policy and Procedure Requirement: The PACT team shall maintain client rights policies and procedures.

XI. Culturally and Linguistically Appropriate Services (CLAS)

United States. Dept. of Health and Human Services. Office of Minority Health. National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report. [Rockville, MD]: U.S. Dept. of Health and Human Services, 2001.

A. PACT should ensure that clients receive from all staff members, effective understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

B. PACT teams should implement strategies to recruit, retain, and promote a diverse staff that are representative of the demographic characteristics of the service area.

C. PACT teams should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

D. PACT teams must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each client with limited English-proficiency at all points of contact, in a timely manner during all hours of operation.

E. PACT teams must provide to clients in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

F. PACT teams must assure the competence of language assistance provided to limited English-proficient clients by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except by request of the client).

G. PACT teams must make available easily understood client-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

H. PACT teams should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

I. PACT teams should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, client satisfaction assessments and outcome-based evaluations.

J. PACT should ensure that data on the individual client's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and be periodically updated.

K. PACT teams should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and client involvement in designing and implementing CLAS-related activities.

L. PACT should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by client.

M. PACT is encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Policy and Procedure Requirement: The PACT team shall maintain written Culturally and Linguistically Appropriate Services (CLAS) policies and procedures incorporating the requirements outlined in this section.

XII. Performance Improvement and Program Evaluation

The PACT team shall have a performance improvement and program evaluation plan, which shall include the following:

A. A statement of the program's objectives. The objectives shall relate directly to the program's clients or target population.

B. Measurable criteria shall be applied in determining whether or not the stated objectives are achieved.

C. Methods for documenting achievements related to the program's stated objectives.

D. Methods for assessing the effective use of staff and resources toward the attainment of the objectives.

E. In addition to the performance improvement and program evaluation plan, the PACT team shall have a system for regular review that is designed to evaluate the appropriateness of

admissions to the program, treatment or service plans, discharge practices, and other factors that may contribute to the effective use of the program's resources.

Policy and Procedure Requirement: The PACT team shall maintain performance improvement and program evaluation policies and procedures.

XIII. Stakeholder Advisory Groups

A. The PACT team shall have a stakeholder advisory group to support and guide PACT team implementation and operation. The stakeholder advisory group shall have at least 51 percent mental health consumers and family members and include other community stakeholders such as representatives from services for the homeless, consumer-support organizations, food-shelf agencies, faith-based groups, criminal justice system, housing authorities, landlords, employers, and/or community colleges. Group membership should also represent the local cultural populations.

The stakeholder advisory group shall:

1. Promote quality PACT model programs
2. Monitor fidelity to the PACT program standards
3. Guide and assist with the administering agency's oversight of the PACT program
4. Problem-solve and advocate to reduce system barriers to PACT implementation
5. Monitor, review, and mediate client and family grievances or complaints
6. Promote and ensure clients' empowerment and recovery values in PACT programs.

Policy and Procedure Requirement: The PACT team shall maintain the written stakeholder advisory group policies and procedures, incorporating the requirements outlined in this section.

XIV. Waiver of Provisions

A. The PACT team may request of the PACT certification entity a waiver of any requirement of this standard that would not diminish the effectiveness of the PACT model, violate the purposes of the program, or adversely affect clients' health and welfare. Waivers cannot be granted which are inconsistent with client rights or federal, state, or local laws and regulations.